

ANNUAL MEDICAL CERTIFICATE			
<p style="text-align: center;">PRIVACY ACT STATEMENT</p> <p>AUTHORITY: NGR 40-501</p> <p>PRINCIPAL PURPOSE(S): To provide medical authority with information to update medical treatment history. Use of Social Security Number is required to make positive identification of individual and records. The information is used to determine continued medical qualification.</p> <p>ROUTINE USE(S): None.</p> <p>DISCLOSURE IS VOLUNTARY: Failure to provide the requested information will result in medical disqualification for retention in the Army National Guard.</p>			
YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	Do you currently have any medical/dental problems?	
<input type="checkbox"/>	<input type="checkbox"/>	Have you had any medical or dental problems since your last periodic physical examination?	
<input type="checkbox"/>	<input type="checkbox"/>	Have you been seen by or been treated by a dentist, physician, or other health care provider since your last periodic physical examination?	
<input type="checkbox"/>	<input type="checkbox"/>	Have you been hospitalized or had surgery since your last periodic physical examination?	
<input type="checkbox"/>	<input type="checkbox"/>	Are you currently taking medication, or have you taken prescription medication since your last exam?	
<input type="checkbox"/>	<input type="checkbox"/>	Are you currently or have you in the past received a VA disability, Workmen's Compensation, or other type of compensation for health or physical reason?	
Current Medications:			
Explain any positive answers above:			
<p>I certify that the above information is true and correct to the best of my knowledge. I further understand that false statements made on this form will be cause for reassignment, discharge, or other disciplinary action.</p>			
DATE	RANK	MOS	NAME (Type or Print)
SSN			SIGNATURE

INITIAL MEDICAL REVIEW - ANNUAL MEDICAL CERTIFICATE

1a. AMC Review Notes (Unit Level - 16-1a)

☐ Fully Fit ☐ Requires Supervisor Evaluation

Signature: _____

1b. Supervisor:

☐ Fully Fit ☐ Requires Further Evaluation

Signature: _____

2. Medical Evaluation Notes (17-3):

RECOMMENDED ACTION:

☐ To MDRB: ☐ Reclassify ☐ Separate
 ☐ Fully Fit ☐ Nondeploy ☐ Deploy

P	U	L	H	E	S

Code(s): _____

Signature: _____

3. Medical Duty Review Board Action: (17-4)

☐ Fully Fit ☐ Reclassify ☐ Separate
 ☐ Nondeploy ☐ Deploy

P	U	L	H	E	S

Code(s): _____

Medical Member

MILPO Member

Member

 NGR 40-501 Appendix B, Page 2, 1 September 1994 (Previous editions obsolete)
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